CHAPTER 1. INPATIENT DENTAL PROGRAM

SECTION I. GENERAL

1.01 POLICY

Dental services in health care facilities will be responsible for providing such dental care as is essential to the veterans' medical needs and treatment planning will be integrated to meet this objective. Dental treatment will include treatment of trauma, control of pain, elimination of acute infection and may be extended to provide definitive care to maintain or augment adequate masticatory function, improve appearance and correct speech deficiencies, as consistent with the priorities for dental care as outlined in paragraph 1.04c.

1.02 HOSPITALIZATION FOR ORAL CONDITIONS

VA Beneficiaries. Hospitalization of VA beneficiaries for oral conditions will be accomplished in accordance with the prescribed policy for all admissions. The veteran will be referred to the dental service for consultation and a professional determination as to the need for admission. Patients admitted for dental care must be given the same careful medical evaluation as those admitted to other services. This evaluation may be provided by a physician-member of the medical staff or by a qualified dentist who has clinical privileges to render such service. A physician will be responsible for the care of any medical problem that may be present at the time of admission or arises during the course of hospitalization.

SECTION II. EXAMINATION AND TREATMENT PROCEDURES

1.03 ORAL EXAMINATION PROCEDURES

a. Forms Involved. The dental service will receive daily, for each patient admitted, VA Form 10-0001, Dental Index Card, with items 1 through 4 completed by Medical Administration Service. At the time of admission, an approved dental record (VA Form 10-7978f or other) will be placed in the patient's health care folder, as a permanent record, for recording the oral examination and, if applicable, the treatment plans. Special overprints on VA Form 10-7978g may be used when locally approved as supplements to the dental record.

b. **Oral Examination--Policy.** An oral examination by the dental service may be provided for any veteran admitted for hospitalization. Special emphasis will be given to those inpatients that have been identified by local protocols as requiring physician/dentist interaction for the management of medical conditions that are complicated by dental disease (see par. 1.07). It is expected that the examiner will have access to the medical record at the time of the examination. Long-term patients are to be reexamined at least every 6 months following the time of last examination or completion of last episode of treatment, whichever is applicable. For those patients who are admitted frequently, a review of the findings of an oral examination accomplished within the past 6 months may be substituted for a clinical examination.

c. **Oral Examination--Types**

(1) **Screening Examination.** Most inpatient examinations will be of this type. At a minimum,

a screening examination will include a determination of the chief dental complaint (if any), a thorough oral and peri-oral soft tissue evaluation and a visual inspection of the teeth and investing structures. Charting of individual teeth is not considered essential. Significant oral findings and major medical diagnoses will be noted appropriately in the dental record. The purpose of the screening examination is to rule out serious oral disease and to establish profiles of patients' dental conditions as a basis for assigning priorities for treatment consistent with the availability of dental care resources. The screening examination does not supplant the complete oral examination as a prerequisite to definitive dental treatment planning and treatment.

(2) **Complete Oral Examination.** A complete oral examination is accomplished by a duly licensed dentist or a designated resident and is usually done only when there is indication that the veteran is to receive dental treatment. This indication may be provided on the basis of an earlier screening examination or from information made available in the medical record or on a consultation request. A complete oral examination will include a thorough oral and peri-oral soft tissue review, a charting of the teeth and periodontium, and an evaluative summary. As necessary, the examining dentist will use professionally indicated radiographs and other special diagnostic procedures. The patient's clinical, radiographic, and laboratory findings and case history will be correlated prior to the establishment of working diagnoses and a treatment plan. The number and type of dental x-ray exposures required will be a determination of the examining dentist. Transillumination of teeth is encouraged where it can be successfully employed to minimize the need for radiographs. However, since no tangible record remains, it will be necessary to carefully describe the findings identified by this method. Oral cytological examination may be used as an additional diagnostic tool, but should not be considered a substitute for biopsy. The routine use of the patient's medical record for diagnostic assistance and pertinent notation is expected. This requires that the medical record be sent to the dental service when the patient is being seen.

d. **Oral Examination as Prerequisite to Priority of Treatment.** Oral examinations are prerequisites to the establishment of priorities for dental treatment. Analyses of either complete examinations or screening examinations may serve for this purpose. However, no dental treatment other than emergency will be provided until a complete oral examination with treatment plan has been accomplished.

e. **Recording Pathologic Conditions.** Reports of oral examinations will be completed in detail and include laboratory results and radiographic findings when appropriate. Any abnormality or pathologic condition of the hard or soft tissues will be documented in the medical record. Oral manifestations indicating probable systemic conditions will be recorded and, as for all oral

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conditions considered to be of priority concern, brought directly to the physician's attention.

f. **Request for Dental Consultation.** A dental consultation for any inpatient may be requested by responsible health care personnel at any time with an SF 513, Medical Record--Consultation Sheet. Although the clinical evaluation should be comprehensive, the consultation response may be limited to positive findings. If complete oral examination and recommendations are indicated, the oral examination record will be completed.

g. **Information to Be Furnished to Patient at Time of Oral Examination.** Patients given an oral examination will be informed that such an examination is a diagnostic service provided as an integral part of their physical examination, not necessarily a basis for correction of dental disabilities, per se. The patient must not be left with the erroneous conception that the accomplishment of an oral examination and the discussion of dental problems or dental treatment needs by the examiner constitutes an obligation on the part of the VA to provide dental care. Caution must be taken through careful communication to avoid any commitment to dental care prior to the establishment of priorities based on medicodental findings or legal entitlement. Nevertheless, it is incumbent upon the examiner to provide the patient with a brief summary of the oral exam findings and an indication of the type of treatment, if any, that would be necessary to restore oral health.

1.04 TREATMENT PLANNING: PRIORITIES FOR AND EXTENT OF CARE

a. **Role of the Oral Examination**

(1) Following a screening examination, the Dental Service Chief or designee will review the medical/dental data and determine if further evaluation and/or treatment is indicated. If so, the patient will be scheduled for a complete oral examination.

(2) A complete oral examination usually implies that medical and/or dental conditions exist for which treatment by the Dental Service is to be considered. The type and extent of treatment recommended generally will be determined on the basis of the total hospitalization requirements. This may indicate treatment for all, some, or none of the dental conditions present.

b. **Policy for Establishing Priorities.** Most VA dental services examine and treat both inpatient and outpatient beneficiaries. It is not the established mission of the VA however, to provide dental care to all veterans or even to all those that are hospitalized. Title 38 U.S.C. chapter 17, sections 610, 611, and 612, as amended, prescribe the applicable authority and restrictions. Aside from emergency care, dental treatment for inpatients will relate to several factors, such as whether the dental condition is detrimentally affecting a medical problem, length of hospital stay, etc. dental treatment for outpatients relates to statutory eligibility granted to veteran beneficiaries, such as former POWs, those with service-connected dental conditions related to trauma, etc. Since VA dental resources are limited, and must be used judiciously, and since the law specifies that dental treatment will be provided on the basis of priorities, it is required that every Chief, Dental Service, develops and implements clinic policy to:

(1) Ensure that treatment recommendations for inpatients are correlated to the patient's medical profile and, as applicable, that this information is used

as the basis for determining priorities for care. Policies will also ensure that outpatients have their eligibility established by Medical Administration Service.

(2) Organize and allocate existing dental resources to provide dental treatment in accordance with the priorities described in paragraph c.

(3) Ensure that the extent of care for each patient prescribed treatment is in accordance with paragraph d.

c. **Determination of Priorities for Dental Care.** The dental service's effectiveness in meeting the treatment needs of both inpatients and outpatients is critical. This effectiveness is cumulatively determined through careful consideration of each patient's particular circumstance (eligibility, dental problems, relationships to medical condition, emergency need, etc.). The degree of treatment commitment to the inpatient population and the extent of absorption of legally eligible outpatient cases must be determined through the firm establishment of PRIORITIES FOR CARE (described below) and EXTENT OF CARE (described in pars. d and e). Although there is not an ordered breakdown of priorities within a particular priority group (Priority I, Priority II, etc.). EACH PRIORITY GROUP'S DENTAL CARE NEEDS MUST BE PROCEEDING TOWARD RESOLUTION BEFORE TREATMENT IS PROVIDED TO ANY PATIENT IN A LOWER PRIORITY GROUP. To comply with this directive, the Chief, Dental Service, must limit delegation of authority for establishing the priorities of care to only those staff dentists who are thoroughly familiar with the mission of the VA and can maintain consistency based on fixed guidelines. The protocol for the provision of dental care will be established according to the assignment of approved treatment plans to the following priority groups:

(1) **Priority I**--Inpatients and outpatients whose statutory eligibility, dental emergencies, compelling medical needs and/or long-term hospitalization place them in top priority consideration for treatment. *These are listed alphabetically, as follows:*

(a) Classes I through VI legally eligible outpatient dental beneficiaries.

(b) Domiciliary patients.

(c) Emergency dental care.

(d) Inpatients (SC/NSC) with compelling medical need for dental treatment. (Reference par. 1.07 regarding the establishment of local protocols for the management of hospitalized patients with medical problems complicated by or related to oral conditions whose treatment is usually in the province of the dental service.)

(e) Inpatients who have been hospitalized continuously for 100 days or more (extended care).

(f) Nursing home care unit patients.

(g) Patients having a compelling medical need for continuation of dental care on a posthospital, outpatient basis.

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(h) Specially designated inpatients and outpatients such as those provided for under approved sharing agreements, eligible allied beneficiaries, and employees officially authorized treatment for work related injuries or conditions, etc., as described in M-4, Dentistry, paragraph 3.03 d.

(2) **Priority II**--Hospitalized veterans whose dental conditions are not considered to be adjunct to their medical problems and who have no direct legal eligibility for outpatient dental care. In this category, service-connected veterans must be considered ahead of non-service-connected veterans.

(3) **Priority III**--Inpatients who do not qualify under Priority I and who are:

(a) **Active duty military personnel.** (Unless covered by the provisions of an approved sharing agreement.)

(b) **Military retirees.** (Unless covered by the provisions of an approved sharing agreement.)

(c) **Beneficiaries under CHAMPVA.**

d. **Determination of Extent of Care.** Once a patient has been properly categorized and the priority for dental care established, the EXTENT OF CARE must be determined. The extent of care is as important in properly allocating dental resources as establishing priorities for care, since over-treatment can dissipate these resources just as surely and quickly as improper priorities.

e. **Combining Priorities for Care and Extent of Care into an Equitable Treatment Protocol**

(1) The VA is obligated to fulfill the requirements of the statutes enacted by the Congress and to follow their intent with fidelity. Every Dental Service has the responsibility to provide dental care on the basis of controlled priority and individual prescription. Every Chief of Dental Service, every VA dentist who authorizes care, and every VA dentist who provides care share this responsibility. A clearly defined treatment plan that is in harmony with these precepts should be identifiable in the medical records of every patient receiving dental care.

(2) No authority exists, nor can there be any justification for providing non-emergent dental care for anyone in Priorities II or III until all the treatment needs of Priority I patients have been satisfied or are in the process of resolution (including those under treatment and transferred from other facilities for necessary continuation of treatment). Likewise, there is no authority to provide dental care to lower priority patients because it fulfills the criteria for a "teaching case." If a training program is overplanned in relation to resident staffing and the available and normally occurring clinical resources, either the scope of the training program must be adjusted or the Priority I cases must all be satisfied or be in the process of resolution, before treatment of lower priority patients, selected primarily for training purposes, can be undertaken.

(3) While the VA has the responsibility to provide dental care on a priority basis, it does not have the obligation to provide dental care in excess of that for which a veteran is eligible or which goes beyond the scope necessary to resolve a medical problem. For example, an inpatient's medical problem may require only the removal of foci of infection. Even though the VA may edentulate the patient to resolve the dental condition's impact on a medical problem, the VA is no more obligated to provide prostheses for this

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patient than a private dentist would be who had edentulated the patient. Unless the patient is a long-term inpatient or has specific legal eligibility to comprehensive care as a VA beneficiary or there remains a compelling medical need for the additional care, the VA will have discharged its obligation and the case should be closed. In addition, preventive measures will be undertaken on an ongoing basis only in those cases which they provide support for medical conditions such as head and neck radiation, renal dialysis, organ transplants, valvular disorders, etc., where continued control of infection is of paramount concern.

f. **Review of Oral Examination Findings by the Physician.** A brief summary of oral examination findings will be written in the progress notes of the patient's medical record for review by the primary care physician. If dental treatment is planned, the progress note will direct the physician's attention to VA Form 10-7978f, the Oral Maxillofacial Defined Data Base (or other approved oral examination record), for a report of the complete exam and the treatment plan. In such case, the physician will also be expected to complete and sign the concluding portion of the oral examination record indicating whether or not the patient is physically able to have the planned dental treatment, the estimated duration of hospitalization, and any other comments concerning the patient's medical condition that are relevant to the proposed dental care.

1.05 INFORMATION TO BE FURNISHED PATIENT REGARDING DENTAL TREATMENT PHASE OF HOSPITALIZATION

Oral diagnosis, treatment recommendations and treatment limitations will be thoroughly discussed with the patient prior to treatment. It should be emphasized that the dental therapeutic measures recommended are not predicated on dental rehabilitation per se, but are to be performed as the dental phase of overall medical management. Each patient will be informed of the administrative procedures and limitations involved in furnishing the dental treatment during hospitalization and/or as posthospital care. Caution must be exercised by all personnel to avoid giving patients unrealistic expectations as to the amount and type of dental care they will receive. Questions concerning eligibility for alleged service-connected dental conditions will be referred to the Chief, Medical Administration Service, for resolution.

1.06 REFUSAL TO ACCEPT DENTAL SERVICES

In those instances where patients refuse to accept the dental services recommended or do not cooperate in receiving treatment, a statement of the facts will be entered in the progress notes and dental record for consideration and appropriate disposition by the patient's primary-care physician and the Chief, Dental Service.

1.07 PHYSICIAN/DENTIST INTERACTION IN THE MANAGEMENT OF PATIENTS WITH SPECIFIED HEALTH PROBLEMS

a. **Health Problems Involved**

(1) Some dental infections or intraoral diseases compromise the medical treatment of particular systemic health problems. In other cases, the patients medical problem(s) or medical treatment may complicate the provision of needed dental care. In the context of providing high quality medical care, it is imperative that each VA medical center establish and maintain a set of locally developed protocols and associated directives to assure identification,

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evaluation and necessary dental treatment of veterans hospitalized for specified medical conditions.

(2) Eleven diagnostic groups have been identified that include disease entities or conditions for which physician/dentist interaction is frequently necessary. The diagnostic groups are as follows:

(a) Head and Neck Malignancy

(b) Cardiovascular Disorders
(c) Advanced Liver Disease
(d) Joint Prostheses
(e) Nutritional and Metabolic Deficiencies
(f) End Stage Renal Disease
(g) Immunocompromised Patients
(h) Pulmonary Disease
(i) Patients with Mental Disorders
(j) Substance Abuse
(k) Physically Handicapped Patients

(3) A number of the diagnoses within these groups may require initial and continuous involvement of dentistry in the interdisciplinary team treatment planning and management of the patients involved. Most of those will be included in the following groups: head and neck malignancy, joint prostheses, cardiovascular disease, and immunocompromised patients. Others, because of (a) deleterious effects of oral infections on medically compromised patients or, (b) the effect of certain medical disorders and/or the side effects of treatment regimens on oral structures or tissues, will require special considerations, precautions, or management strategies. Also represented in these groups are patients with certain disorders and diseases who would be difficult to manage or be at significant risk if treated in a non-hospital setting.

b. **Responsibility for Implementation of Interdisciplinary Treatment Protocols**

(1) It is the responsibility of the Chief of Staff, or designee, to assure maintenance of locally developed interdisciplinary protocols and, through appropriate mechanisms, to monitor the quality of interdisciplinary care.

(2) Chiefs of Clinical Services having primary treatment responsibility for patients with diagnoses included in the diagnostic groupings will maintain procedures assuring that protocol patients are provided the opportunity for dental service evaluation and access to needed dental therapy.

(3) Physician and dentist members of the medical staff will coordinate the identification, referral, consultation and interdisciplinary management of patients in accordance with these protocols. In affiliated medical centers where residents rotate with some frequency throughout the training year, the Chiefs of Services to which the residents are assigned will assure that the residents maintain the continuity of interdisciplinary care.

(4) The Chief, Dental Service, will have primary responsibility for determining the appropriate level and extent of dental care for patients identified in the treatment protocols. The Chief will also establish dental staff responsibility for the coordination with the primary care physician(s) for the dental care of those patients.

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(5) Chiefs of Dental Service will also ensure that their inpatient resources are directed toward meeting the needs of patients in established protocols. The Program Guide entitled Interdisciplinary Management of Patients Having Medically Compelling Needs for Dental Treatment provides related information and examples of content and format that may be helpful for local protocol development.

c. **Procedural Guidance for Interdisciplinary Treatment Protocols**

(1) The examination program of the Dental Service and consultation requests from primary care physicians will be the chief operational mechanisms to identify patients who fall within the protocol groups. Identification by these means should be accomplished as soon after admission (or diagnosis of the applicable disease process) as possible so that the dental component of care will not impede primary medical care or prolong hospitalization. Pre-admission and post-discharge treatment planning will assure the most cost-effective approach as well as considerate, high quality care of these patients.

(2) Local policy, protocols, or directives must clearly state that, unless additional entitlement exists, dental care for patients in these diagnostic groups will be generally limited to treatment that is directly related to the medical problem. Presentation of interdisciplinary plans to patients should not give unrealistic expectations as to the amount and type of dental care they will be receiving.

(3) Quality assurance guidelines will be maintained to assure that patients are receiving dental evaluation and care consistent with the intent of this directive and in compliance with locally developed protocols.

1.08 PROCEDURES APPLICABLE TO TREATMENT OF LONG-TERM PATIENTS

a. **Responsibilities.** As indicated by the priorities listed in paragraph 1.04c, the VA assumes responsibility for dental care of patients hospitalized for long periods of time (over 100 days), including those admitted to Nursing Home Care Units and Domiciliaries. In addition to Dental Service personnel, the oral health of these patients must be a concern of physicians, nursing staff, dietitians, social workers and other therapists who come in contact with them on a day-to-day basis. Where interdisciplinary teams plan and implement care, a dentist should serve as an active participant or as a consultant and treatment plans for each long-term care patient should include a dental component.

b. **Oral Examination and Treatment Plan.** When it becomes evident that a veteran will be hospitalized or in the NHCU or domicilairy for over 100 days, a complete oral examination should be provided and a dental treatment plan formulated. The plan will be based on the patient's functional abilities as well as patient's medical problems and dento-oral status. Depending upon the patient's condition and prognosis, dental care may be limited to procedures eliminating pain and acute infection; or may be expanded to provide sufficient masticatory function to allow the patient to partake of a palatable as well as a nourishing diet. In any case, it will include preventive orientation and/or access to oral hygiene.

c. **Mental and Functional Disabilities.** The fabrication of commercially available or customized innovative devices to assist the oral hygiene practices

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of patients with functional disabilities is encouraged. This would include electric toothbrushes and oral irrigating appliances. Nursing personnel will be given instructions in the provision of daily oral hygiene procedures for patients who are unable to care for themselves. If the patient's mental state, age, or infirmity impair patient's ability to adequately comprehend, consent for any emergency dental care that is required will be obtained in accordance with paragraph 4.06f or g.

1.09 MEDICAL RECORDS: CRITERIA FOR DOCUMENTATION

a. Preparation and Use of VA Form 10-7978f, Oral Maxillofacial Defined Data Base, Part VI. This record will be an integral part of the consolidated health record. It is recognized that there will be variations in the ways this record format will be used because of the different methods employed by individual health care facilities. It is further recognized that for an interim period of time there will be opportunities for local facilities to develop and utilize alternative documentation methods which are approved by Central Office. However, for those Dental Services who are not granted exemption to the existing VA Form 10-7978f, the following general instructions will apply:

(1) **Item A, Chief Complaint.** List the patient's dental problems, if any, stated in the patients own words.

(2) **Item B, History of Present Illness.** Give a brief chronological description of the patient's chief dental complaints including date and mode of onset and symptoms such as pain, swelling, bleeding, past treatment if any, etc.

(3) **Item C, Past History.** Self-explanatory.

(4) **Item D, Clinical Examination.** This is a most important part of the patient's evaluation. Refer to paragraph 1.03c and e.

(5) **Special Dental Records.** If local facilities desire to use special records with a more extensive legend they may do so. However, any special forms used for this purpose will be used as an addition to VA Form 10-7978f, not in place of it. If at the completion of the episode of treatment there is need to retain the optional supplemental form for future reference, it may be filed with the patient's radiographs in the radiograph envelope, VA Form 10-2636 or VA Form 10-2536a.

(6) **Item G, Significant Laboratory and Radiographic Findings.** All significant diseases or other abnormal conditions revealed by the radiographic examination will be recorded. It is also desirable to note those laboratory findings that are relevant to the oral disease present or which may be significant to the course of dental treatment.

(7) **Initial Assessment and Plans.** Once the examination is complete, the dentist will, on the basis of the history, and the clinical, radiographic, laboratory and medical findings, assess the problem and record the assessment and plans on the dental form.

(a) **Assessment.** In the assessment, the type and extent of oral disease present is described, informing the physician what effect the oral condition may have on the patient's medical problem and general health.

(b) **Plans.** If, in the opinion of the dentist, the treatment of the dental condition(s) is not considered to be an essential part of the treatment for the patient's medical problem(s), a statement to this effect should be noted. If treatment is planned, it will be in accordance with the principles and guidelines given in paragraphs 1.04a and b and will be recorded according to following format as appropriate:

1. **Diagnostic (Dx).** Identifies any additional tests necessary to provide information regarding tentative or questionable diagnoses.

2. **Therapeutic (Rx).** Identifies the type of treatment planned for this episode of hospitalization such as extractions, restorations, periodontal treatment, etc.

3. **Patient Education.** Describes information provided patients concerning their oral conditions. All patients who receive treatment will be given instruction in proper oral hygiene practices and, if prostheses are furnished, instructions in their proper care. Patients should be advised of the relationship of their oral disease problems to their medical condition and general health. Patients having dental conditions for which treatment is not considered essential for care during hospitalization should also be advised of their dental problems and encouraged to seek private care.

(8) The examining dentist will sign and date the form in the space indicated.

b. **VA Form 10-1415, Problem List.** The patient's dental complaint, history of present dental problems, clinical examinations, roentgenograms, laboratory findings and review of the medical data will be correlated to establish the patient's oral maxillofacial problems. Those problems for which treatment is considered necessary will be entered on the problem list, VA Form 10-1415. All dental conditions that are entered on the problem list will have a date of onset, if known, and a date of entry followed by the problem. An arrow is drawn after the condition and when treatment is started the date is placed over the arrow. This date simplifies the index by allowing location of information in the progress notes. At this point, the dental record is ready for review by the patient's physician. (See par. 1.04c). In order to expedite dental care, it is recommended that the doctors orders be annotated to indicate that the dental record is ready for the physician's review. The record is flagged so the ward secretary will call this to the attention of the physician.

c. **Maintenance of Records.** Dental services performed will be entered in the progress notes and identified by the title of the problem. If desirable or indicated, the SOAP (subjective, objective, assessment, and plans) format may be used for entries in the progress notes. However, if the only dental progress note entry describes treatment of a specific problem, record only the pertinent aspects such as the problem title and the therapeutic procedure(s). When the dental treatment related to a problem has been completed, or the patient is being discharged, the date will be placed below the arrow on the problem list, and the dental summary completed. (See subpar. e.)

d. **Doctors Orders and Progress Notes.** Entries in the doctors orders will be made when indicated. As previously described, all dental treatment is recorded in the progress notes. When hospitalization is principally for dental care, the progress notes and doctors orders will be written primarily by the

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dentist caring for the patient. The dentist will also prepare and sign the final summary in such cases.

e. **Summary of Dental Care.** At the conclusion of dental treatment or on discharge, in order to assist the Medical Record Administrator in reviewing VA Form 10-1000, the dental service will list in the progress notes under the heading "Dental Summary" the diagnoses of the treated dental conditions. Services planned for completion on an outpatient status should also be

recorded. Any unusual circumstances or occurrences which the physician may want to include in the final summary should be stated briefly in the dental summary. The diagnoses will be consistent with the terminology from the latest available edition of the American Medical Association's "Current Medical Information and Terminology" as well as the terminology used in the International Classification of Diseases manual to allow for proper medical records ICD-9 coding. Treatment procedures should also be listed using the terminology from the latest edition of "Current Procedural Terminology" of the American Medical Association. Where utilization of these references is not feasible, then other approved references may be used.

f. **Security and Return of Medical Records.** The Chief, Dental Service, will be responsible for the security and prompt return of all medical records of patients referred to the dental service.

1.10 CONTINUATION OR TERMINATION OF TREATMENT

a. **Designation of Dental Treatment Status Prior to Discharge.** Prior to discharge, and as early during the hospital stay as possible, it will be incumbent upon the member of the medical staff having primary responsibility for the care of a hospitalized patient and the Chief, Dental Service (or designee), to coordinate the proper disposition of patients for whom dental care is in progress or is to be initiated during hospitalization. Proper planning should avoid extending inpatient status for the sole purpose of completing dental care. When discharge is imminent, a determination must be made whether or not the dental treatment provided has accomplished the intended objectives with relation to the medical condition of the patient. If essential dental treatment has been completed, inpatient dental care should be terminated. If essential care remains, the discharge planners must determine whether it will be continued with the patient as a bed occupant or as an outpatient. Except in unusual circumstances, patients being discharged to contract nursing homes or hospital-based home care should have all necessary care completed prior to discharge. If inpatient dental treatment has resulted in depletion of the patient's dentition, no commitment for prosthestic replacements will be made without applying the rationale and guidelines contained in paragraph 4.09a.

b. **Post-Discharge Treatment for Veterans with Statutory Eligibility for Outpatient Dental Care--Classes I through VI Status.**

(1) **Classification.** The Chief, Dental Service, in coordination with Medical Administration Service, will take appropriate action to ensure completion, on an outpatient basis, of the treatment planned for service-connected dental conditions for which the veteran has clear statutory eligibility (including dental conditions determined adjunct to a patient's service-connected medical disabilities) when such treatment cannot be completed prior to discharge. The patient's eligibility will be determined by Medical Administration Service and the veteran classified under one of the Classes I through VI categories. Any remaining uncompleted treatment for which the veteran is eligible will be recorded on VA Form 10-2570 as the outpatient treatment plan.

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(2) **Referral.** When circumstances preclude treatment at the discharging facility due to geographic inaccessibility, Medical Administration Service will determine if there is another VA health care facility within reasonable distance from the veteran's residence and that that facility can provide the care in a timely manner (initiate treatment within 60 days). In such a case, the consolidated health record will be forwarded to the VA facility which will provide the

care. If another federal facility with which the VA has an established contract or sharing agreement is to provide the needed outpatient dental care, only copies of the pertinent records will be forwarded. If none of these options exist, Medical Administration Service will make arrangements with the appropriate VA clinic of jurisdiction to contract the dental care on a fee-basis. A VA beneficiary will not be referred for fee-dental care without a valid and justifiable reason. The decision for fee-dental care is not the prerogative of the veteran but is a VA decision based on the lack of availability of VA or other federal resources to provide the needed care. In all cases where referral takes place, the veteran will be notified and fully apprised of the action taken.

c. **Post-Discharge Outpatient Dental Treatment for Veterans Who Do Not Qualify Under Classes I-VI.**

(1) **Classification.** If a patient who does not have Class I through VI eligibility requires post-discharge dental care, the Chief of Dental Service, or designee, in coordination with the responsible staff physician, must arrange for the patient's return with the Medical Administration Service proir to discharge. For MAS purposes, the patient will be classified as either OPT/SC or OPT/NSC depending upon whether the medical treatment involves a service-connected disability. It should be noted, however, that the dental data system does not differentiate on this basis, and all such cases will be carried as "continuation of care."

(2) **Professional Considerations.** The commitment for post-hospital care to patients who would otherwise be ineligible for outpatient care must be restricted to only those individuals whose dental conditions are professionally determined to have a direct detrimental effect on the medical condition(s) of current concern. For whatever extent of dental care is to be provided, there must be an understandable and defensible position based on sound professional judgment relative to the dental impact on the medical problem. The patient's inability to defray the cost of private dental care cannot be a factor in determining the extent or limitation of dental treatment which will be provided by the VA. At time of discharge from the hospital, any remaining definitive dental care which does not significantly relate to a medical problem will be terminated. The only exceptions will be situations which would clearly constitute abandonment of a patient under treatment, such as need for post-operative evaluation, sutures in place, unrestored crown preparations, etc. Under these circumstances, those essential components of the dental treatment will be completed at the earliest possible opportunity. In cases where treatment is not to be continued, the veteran must be informed of any need for further care and counseled to seek it elsewhere. It is medico-legally important that such counseling be documented in the medical record.

(3) Referral. Patients who are to be followed on an outpatient basis and who reside long distances from the discharging facility may be treated at the VA health care facility closest to their homes. Advance arrangements must be made between Chiefs, Dental Services, of the facilities involved in accommodating reasonable requests for these patient care needs. Transfer of records will be accomplished by Medical Administration (M-1, part I, chapter 5).

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1.11 QUALITY OF CARE-DENTAL SERVICE QUALITY ASSURANCE PROGRAM

a. **Integration with the Facility Quality Assurance Program.** With proper adherence to priority and extent of care, the primary responsibility of the dental service is to provide delivery of high quality cost-effective dental treatment. To such delivery, it is

imperative that appropriate procedures be established and implemented to review applicable aspects of the delivery system and resolve problems that are identified. The Dental Service Quality Assurance Program, while being specific for dental, must be integrated with and follow guidelines established for the facility QA Program. In most instances, the facility program will be carried out in the following areas:

(1) Continuous Monitoring of Generic Screening Elements
(2) Utilization Review
(3) Peer Review
(4) Risk Management and the Internal Control Program (A-123)
(5) Credentialing and Privileging of Staff

b. **Dental Service Quality Assurance -- Responsibilities and Activities.**

(1) Each Chief, Dental Service is responsible for establishing adequate measures to:

(a) Monitor and evaluate the quality and appropriateness of dental care provided to VA beneficiaries.

(b) Review credentials of applicants for appointment, and grant or renew privileges of dental staff on the basis of their qualifications, current competence and clinical performance.

(c) Monitor and evaluate safety measures related to patients, patient care, staff activities and environment.

(d) Appropriately resolve or correct problems detected.

(e) Institute follow-up action to ascertain that corrective action has remedied such problems.

(2) Each dental service must have a written plan outlining specific QA procedures and maintain a file of QA activities and results which document operation of the program.

c. **References.** The VA Program Guide "Quality Assurance Program for Dentistry" provides detailed examples of implementation procedures and format and should serve as the basic reference guide for development of facility programs. The Chief, Dental Service, should also have access to the following references for added understanding and input to the overall facility QA program:

(1) VA Manual, M-1,Part I, Chapter 5, Medical Records.
(2) JCAH Accreditation Manual for Hospitals.
(3) JCAH Long Term Care Standards Manual.
(4) VA Regulation 6507(a)(4)i.

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(5) VA Manual, M-2, part I.
(6) Confidentiality Regulations Title 38 U.S.C. 3305 and 38 CFR Part 17.
(7) Information Bulletin "Oral Health for Long-Term Care Patients".
(8) DM&S Circulars and Interim Issues on QA issues.